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	1. TRANSMITTAL NUMBER: 2. S	STATE:
TRANSMITTAL AND NOTICE OF APPROVAL OF		ONTANA
STATE PLAN MATERIAL		
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XI SECURITY ACT (MEDICAID)	X OF THE SOCIAL
TO: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE	
HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	10-01-01	
5. TYPE OF PLAN MATERIAL (Check One):		
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CO	DNSIDERED AS NEW PLAN 💹 AMEN	DMENT
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AME	NDMENT (Separate Transmittal for each amendn	ment)
6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:	
	a. FFY 01	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED	D PLAN SECTION
Supplement to attachment 3.1A & B Serv 4b	OR ATTACHMENT (If Applicable):	
Page 1 of 1	Supplement to attachment 3.1A	& B serv 4b
Supplement to attachment 4.19B, Serv 4b	page 1 of 1	
page 1 of 1	Supplement to attachment 4.19	b serv 4b
	page 1 of 1	
10. SUBJECT OF AMENDMENT:		
Clarifying reimbursement language & clarify	experimental services - 3.1A - 3.	.1B
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11. GOVERNOR'S REVIEW (Check One):		
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT	OTHER, AS SPECIFIED:	
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED		
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12. SIGNATURE OF STATE AGENCY OFFICIAL: 13. TYPED NAME: Gail Gray 14. TITLE: Director 15. DATE SUBMITTED: 10-01-01 FOR REGIONAL OF 17. DATE RECEIVED: October 3, 2001 PLAN APPROVED - 0 19. EFFECTIVE DATE OF APPROVED MATERIAL: 21. TYPED NAME:	Single state agency 16. RETURN TO: DPHHS Gail Gray PO Box 202951 Helena MT 59620-2951 Attn: Denny Gemmell FICE USE ONLY 18. DATE APPROVED: ONE COPY ATTACHED 20. SIGNATURE OF REGIONAL OFFICIAL: 22. TITLE:	

POSTMARK: October 2, 2001

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Page 1 of 1 Supplement to Attachment 3.1A Service 4.b EPSDT

MONTANA

The following limitations apply to Early Periodic Screening Diagnosis and Treatment Services. Services considered experimental are not a benefit of the Montana Medicaid Program.

Experimental services include:

- 1. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.
- All procedures and items, except prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services or any other appropriate federal agency to demonstrate whether the item or procedure is safe and effective in curing/preventing, correcting or alleviating the effects of certain medical conditions. Prescribed drugs approved for use under investigational drug status by the approved federal drug administration and provided under specific controlled medically supervised programs, under the supervision of a physician licensed to practice medicine are not considered experimental for persons eligible for EPSDT.
- 3. All procedures and items, including prescribed drugs, considered experimental but not covered in #1 and #2 above, will be evaluated by the Department's designated medical review organization.

Montana will meet the requirements of Section 1905(r) of the Social Security Act and provide for the medically necessary service for which coverage is mandated by Section 1905(r).

Page 1 of 1 Supplement to Attachment 3.1B Service 4.b EPSDT

MONTANA

The following limitations apply to Early Periodic Screening Diagnosis and Treatment Services. Services considered experimental are not a benefit of the Montana Medicaid Program.

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Montana will meet the requirements of Section 1905(r) of the Social Security Act and provide for the medically necessary service for which coverage is mandated by Section 1905(r).

Approval Date 12/17/01

TN No. <u>01-021</u> Supersedes TN # **99-007** Effective Date: 10/01/01

Page 1 of 1
Attachment 4.19B
Methods and Standards for
Establishing Payment Rates
Service 4.b
EPSDT

MONTANA

The Department will reimburse Medicaid providers for EPSDT services based on the lower of:

- 1. the provider's usual and customary (billed) charge for the service;
- 2. the Department's fee schedule; or
- 3. when the Department has not established a fee schedule, a rate negotiated with the provider.